

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003062

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 6048Primary Registration District No. 306Registrar's No. 26

STATE FILE NUMBER

FILED JAN 15 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>O'Fallon, Mo</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>O'Fallon, Mo.</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Roeper Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>423 Woodlawn, O'Fallon, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>M</u> Last <u>Griesenauer</u>		4. DATE OF DEATH Month <u>1-</u> Day <u>7-</u> Year <u>63</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (last birthday) <u>79</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (City, and state or country) <u>Wentzville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Fox</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Hanebry</u>	
14. NAME OF HUSBAND OR WIFE <u>Joseph D. Griesenauer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mrs. T. Ginnever- O'Fallon, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last: <u>Arteriosclerosis</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>The patient</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>O'Fallon, Mo</u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>Jan 2, 1963</u> to <u>Jan 7, 1963</u> and last saw her alive on <u>Jan 7, 1963</u> Death occurred at <u>10:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Donald G. Wenzel DO</u>		22b. ADDRESS <u>103 E. Pitman, O'Fallon, Mo.</u>	
22c. DATE SIGNED <u>1-10-63</u>		22d. LOCATION (City, town, or county) (State) <u>O'Fallon, Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption</u>	23d. LOCATION (City, town, or county) (State) <u>O'Fallon, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Jerry A. Davis O'Fallon, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-11-1963</u>	
26. REGISTRAR'S SIGNATURE <u>E.A. Keithly</u>		27. DATE SIGNED <u> </u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

JAN 30 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Jerry A. Davis

Licensed Embalmer No. 5139

P. O. Address

Challong, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.